Client Alert.

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Time for a Year-End Checkup: Health Care Reform Action Items for Large Employers in 2010/2011

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On March 23, 2010, President Obama signed into law two pieces of legislation, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (these will be referred to collectively as "the Act"), which collectively impose significant new compliance obligations on employers maintaining group health plans.[1] This Alert focuses on certain provisions of the Act that apply to group health plans maintained by large employers and that require action in 2010 and 2011.

The Act provides that many existing group health plans are "grandfathered," while others are not; grandfathered plans are subject to only a subset of the requirements imposed by the Act while non-grandfathered plans are subject to the full range of requirements, as discussed below. In this Alert, we focus on how a plan may lose or retain grandfathered status and the consequences of each of these alternatives.

PROVISIONS OF THE ACT THAT APPLY TO ALL PLANS

All group health plans, regardless of grandfathered status, are subject to many provisions of the Act; however, grandfathered plans may be granted additional transition time for compliance with portions of the Act and may avoid some of the more onerous new requirements altogether. The following requirements of the Act apply to all group health plans regardless of their grandfathered status.

Summary Plan Descriptions and Summary Material Modifications.[2] The Act generally requires a group health plan to provide advance notice of a material plan modification at least 60 days prior to the effective date of the change. This is a change to the prior disclosure requirement under ERISA, which did not require that notice of health plan changes be delivered in advance of such changes.[3] The Act provides that this advance disclosure requirement is effective for plan years beginning on or after March 23, 2010 (for calendar-year plans, this is January 1, 2011; plans with fiscal plan years may have an earlier or later deadline for compliance) (the "Effective Date").

Expansion of coverage for children up to age 26 for medical coverage. A significant change adopted by the Act is its requirement that group health plans generally extend coverage to an employee's children through their twenty-sixth

[1] Beyond its group health plan mandates, the Act adopts significant changes to other aspects of the health care delivery system ranging from the creation of state-based health care exchanges to the imposition of excise taxes for so-called "Cadillac plans" offering rich health benefits to highly-paid individuals to the much-discussed mandate requiring individuals to secure health coverage or pay an additional tax. This Alert does not address these additional mandates, which generally do not start to become effective before 2012 and all of which are very much "works in progress" at the regulatory level. Further, the Act imposes somewhat different requirements on group health plans maintained pursuant to collective bargaining agreements; we have left the discussion of these more specialized requirements to a later day.

[2] Although many employers —particularly those with fully-insured plans — have historically relied on documentation supplied by their insurance carriers to satisfy ERISA's plan documentation and disclosure requirements, in most instances, insurance policies, group insurance certificates, and evidence of coverage booklets do not contain all of the information required by ERISA or desirable for plan administration purposes. These gaps in coverage can be remedied by the adoption of a "wrap-around" or umbrella summary plan description to supplement the materials supplied by insurance carriers.

[3] The prior SPD/SMM disclosure requirements under ERISA do not require notification to employees of a material modification via a summary of material modifications until 210 days after the end of the plan year in which a change is adopted.

birthdays, regardless of their residence or marital, financial, employment, or student status; this extension of coverage must be made available no later than the Effective Date. For purposes of the extended coverage, the term "children" includes sons, daughters, stepchildren, adopted children, and foster children. Plans and issuers may condition coverage for other dependents, i.e., grandchildren, nephews, or nieces, on existing Internal Revenue Code dependent status under Code Section 152. Employers may not vary the terms of coverage based on age, such as charging additional premiums for children age 19 through 25 (they must be charged the same premium that younger children are charged), nor may fewer or less advantageous benefit options be provided. Coverage must be made available to children who are not currently covered by the plan (i.e., children who previously "aged out" of coverage or otherwise lost dependent status), which may mean that a special 30-day enrollment period is required to readmit these children.[4] The requirement to cover adult children excludes dental and vision coverage (unless such coverage is elected as one package with health coverage for a premium that covers health, dental, and vision benefits), and does not require coverage to be made available for the spouse or child of the adult child.

The Act also provides for exclusion of imputed income of employer health benefits (including dental, vision, and flexible spending/cafeteria plan benefits) from taxation through the end of year in which an employee's child turns twenty-six. This provision was effective March 30, 2010, and therefore extends to coverage made available during 2010. This change should simplify payroll administration because it allows employers to avoid the need to impute income to employees who elected to cover their non-dependent children during 2010.

For grandfathered plans, a transitional rule for the coverage of adult children is in place until 2014. From now until plan years beginning January 1, 2014, the adult child coverage mandate applies only if the child is not eligible to enroll in another employer-sponsored group health plan. In other words, if an otherwise-eligible adult child is eligible to enroll in a group health plan maintained by his or her employer, a grandfathered plan covering the child's parent will not be required to extend coverage to the child, whether or not the child actually enrolls in the alternative coverage. The employer may require that an affidavit be signed by the adult child and his or her employer to help police this exclusion. For plan years beginning on or after January 1, 2014, the extended coverage mandate will apply to all group health plans, even if the adult child is eligible for coverage under some other employer-sponsored group health plan.

The Act imposes a new notice requirement to advise employees about extended coverage available to adult children. To deal with this notice requirement, plan documents and summary plan descriptions ("SPD") may need to be amended; alternatively, employers are permitted to provide a separate notice and some may find this an easier approach to administer for the 2011 open enrollment season.

Employers may wish to consider how the addition of this new population of covered individuals may impact the costs of providing benefits and to explore cost-sharing alternatives.[5]

Lifetime and annual dollar limits. Lifetime limits on the value of "essential health benefits" are prohibited under the Act, as of the Effective Date. "Essential health benefits" include ambulatory care, emergency care, hospitalization, maternity and newborn care, pediatric care (including vision and dental care), mental health and substance abuse services, prescription drugs, rehabilitation services and devices, lab services, and preventive care. There are transitional rules for

[4] Given the timing of this requirement, many plans will use their annual enrollment period to readmit newly-eligible adult children.
[5] As discussed below, employers wishing to preserve the grandfathered status of their plans should use some care in making changes to cost-sharing and other modifications that may increase employee costs with some care; many changes employers have historically made to their plans in response to increased costs of coverage may jeopardize grandfathering.

individuals who have previously reached the lifetime limit: such individuals must be given notice that the limit no longer applies, and be given a new enrollment opportunity of at least 30 days. Annual limits on benefits can continue in a limited fashion until 2014. In particular, annual limits on essential health benefits are restricted to $750,000 for the first year beginning on or after the Effective Date, $1.25 million for the next year, and $2 million for the third year. Plans and SPDs may need to be amended to comply with these rules, and "stop-loss" insurance may become more important for self-funded plans as annual and lifetime coverage limits increase and eventually disappear altogether.

Rebates. Effective January 1, 2011, health insurers are required to maintain their medical loss ratios at less than 85% for large group plans (more than 100 employees) or less than 80% for small plans. In other words, health insurers will be required to spend 80-85% of premium dollars on medical care and quality improvement, rather than on administrative costs and other overhead. If this requirement is not satisfied, a health insurer will be required to provide a rebate to their employer policyholders starting in 2012. Not everyone is a winner under this requirement since the rebate requirement applies only to fully-insured plans; self-funded employers can console themselves by thinking about all of those unpleasant state insurance requirements they aren't required to comply with.

Pre-existing condition exclusions prohibited for children. As of the Effective Date, pre-existing condition exclusions may not be applied to children under the age of nineteen. Prohibited pre-existing condition limitations include denial of coverage, denial of enrollment, and denial of specific benefits. Compliance with this mandate may require plan and SPD amendments, although for the majority of group health plans that are already subject to HIPAA's rules relating to pre-existing condition limitations, significant changes may not be necessary.

Over-the-Counter Drugs. Flexible spending accounts (FSAs), healthcare reimbursement accounts (HRAs), and health savings accounts (HSAs) are prohibited from reimbursing expenses of over-the-counter drugs, except insulin or as prescribed by physician. This rule is effective for purchases made after December 31, 2010. The Act's new limits affect drugs only; other over-the-counter items such as medical devices, eyeglasses, contact lenses, co-pays, and deductibles still may be reimbursed, subject to the applicable plan terms. Plans and SPDs may need to be amended to comply with these rules, but the Act does grant some leeway: any necessary amendments must be made by June 30, 2011, and apply retroactively to purchases made after December 31, 2010 (or January 15, 2011, for debit card purchases).

Insurance Rescission. The Act prohibits rescission of health insurance coverage except for fraud or intentional misrepresentation of material fact (with 30 days' notice). The purpose of this prohibition is to prevent group health plans and insurance issuers from cancelling coverage when an individual makes an inadvertent mistake on an application, and the cancellation results in the termination of all coverage for such individual. This rule applies to both insured and self-funded health plans. The Act permits prospective cancellation or discontinuance of coverage, if the participant is found ineligible for the coverage. Cancellation may also be allowed, prospectively, for nonpayment of premiums or contributions.

Early Retiree Reinsurance Program. Under the Act, $5 billion was provided by Congress to subsidize 80% of medical and prescription drug costs between $15,000 and $90,000 for early retirees (age 55 and older who do not qualify for Medicare) and their spouses and dependents. The funds from the program may be used to reduce employer costs, provide premium relief for employees, or both. Employers must apply to the program and be accepted in order to receive subsidies. In order to participate in the program, the plan must include programs and procedures that have generated (or have the potential to generate) cost-savings with respect to participants with high-cost and chronic conditions. The application process is currently open for both insured and self-funded plans; thus far, over 3,000 employers and unions

have been accepted into the program. Applicants are being accepted on a first-come, first served basis, and may submit medical care claims for reimbursement retroactive to June 1, 2010. The program terminates December 31, 2013, or when funds run out; funds are expected to run out in 2011. Plan sponsors participating in the early retiree reinsurance program must provide all plan participants with a form notice, informing them that because the sponsor is participating in the program, the sponsor may choose to use the reimbursements to reduce plan participants' premium contributions, copayments, deductibles, co-insurance, or other out-of-pocket costs, and therefore plan participants may experience such changes in the terms and conditions of their plan participation.

Phase out of "donut hole" for Medicare beginning in 2010. One of the less popular features of the Medicare Part D prescription drug benefit is the so-called "donut hole" where reimbursements are temporarily phased out. Beginning in 2010, individuals who are enrolled in Part D will receive a $250 rebate to partially fill the donut hole. In 2011, the price of name-brand drugs will be reduced by half for individuals who are in the donut hole, and generic drugs for the same population will have reduced cost-sharing requirements. By 2020, the donut hole will be phased out so that enrollees will simply pay 25% of the cost for prescriptions once they reach the donut hole. These changes may make participation in Part D more attractive to employees as compared to the retiree drug subsidy.

Reporting of value of health care on W-2. As part of the Act's goal of increasing transparency in health care transactions and empowering employees to make health care choices that support cost-containment, beginning in 2012 (or perhaps later — see below), employers will be required to include the value of the health care coverage they provide on employees' Form W-2. This requirement was originally scheduled to take effect for Forms W-2 that relate to 2011 wages (i.e., for reporting to be done in January 2012). However, the IRS has delayed the effective date by at least one year. While mandatory reporting is not yet required, employers may still choose to report the value of health coverage on Forms W-2 issued for calendar 2011.

Automatic enrollment. Under regulations to be issued by the Department of Labor, employers with two hundred or more employees will be required to automatically enroll new full-time employees in one of the group health plans such employers offer (subject to any waiting period authorized by law) and continue the enrollment of current employees in health benefits they offers. Automatic enrollment programs must include adequate notice and the opportunity for an employee to opt out. Congress apparently wanted to create an air of mystery about this requirement since it neglected to specify an effective date. Presumably, the regulations to be issued by the DOL will clarify when the requirement first applies to employers, although employers with an aversion to risk may prefer to attempt to comply with the rather spare statutory requirement as it is in lieu of waiting for further regulatory guidance.

New Notices. The following additional notices are required to be provided under the Act for all group health plans when applicable:

- Notice Regarding New Rules Limiting Reimbursement for Over-the-Counter Medications.
- Notice of Special Enrollment Period for Adult Children.
- Notice of Special Enrollment Opportunity with Respect to Individuals Previously Excluded from Coverage Because of a Lifetime Limit.
- Notice of Grandfathered Plan Status (see below for more discussion).

PROVISIONS OF THE ACT THAT APPLY ONLY TO NON-GRANDFATHERED PLANS

A number of provisions of the Act apply only to non-grandfathered plans. Therefore, to minimize compliance costs, employers may wish to keep their plans grandfathered under the Act.[6] The grandfathered rules are complex, but we set forth the basics below.

How to lose grandfathered status:

The Act provides that certain of its mandates are not applicable to grandfathered plans. To assist employers in evaluating their options, the DOL, the IRS, and the Department of Health and Human Services collectively issued interim final regulations specifying the circumstances in which a plan may retain (or lose) its grandfathered status.[7] For purposes of analyzing the status of a plan, the coverage that was in effect on March 23, 2010, is the measuring point: in many cases, changes to the March 23, 2010 coverage for 2011 or later plan years will cause a plan to lose its grandfathered status. The grandfathering analysis outlined in the regulations can be complex and requires a certain amount of "slicing and dicing" of coverage alternatives; each type and provider of benefit is considered separately when determining whether grandfathered status is maintained. A single group health plan may have both grandfathered and non-grandfathered benefit packages, making effective participant communications a significant challenge.

The following modifications will cause a benefit package to lose grandfathered status:

- Elimination of all or substantially all benefits for a particular condition (i.e., all benefits related to cystic fibrosis);
- Any increase in percentage cost-sharing or co-insurance requirement;
- An increase in fixed-amount cost-sharing requirements by more than the specified medical inflation rate plus 15%;
- An increase in copayment requirement greater than $5 (as increased by medical inflation) or the specified medical inflation rate plus 15%;
- A decrease in employer contribution rate by more than 5 percentage points of the contribution rate as in effect on March 23, 2010;
- The addition of a new policy, certificate, or contract of insurance effective after March 23, 2010, but before November 15, 2010; or
- Certain changes in annual limits including the addition of an annual limit to plans with no existing lifetime or annual limits or an annual limit to a plan with a lifetime limit that is less than the lifetime limit as of March 23, 2010, or a decrease to the annual limit as in effect on March 23, 2010.

New employees and their family members may be safely added to a grandfathered plan, including both new hires and current employees who are new enrollees in the plan. Premiums and limited amounts of cost-sharing may also be changed for grandfathered plans, subject to the limitations described above. Other changes that will not cause a plan or benefit to lose grandfathered status include changes to comply with legal requirements generally or to voluntarily comply

[6] Employers that have already dealt with their 2011 insurance renewals will most likely be aware of the cost impact of grandfathered versus non-grandfathered status: at least for 2011, health insurers can be expected to propose higher premium rates for non-grandfathered plans due to the additional compliance responsibilities associated with them.

[7] Note that these regulations are subject to comment from interested parties and may be modified before they are finalized. For example, the regulators recently issued guidance walking back part of the interim final regulations on grandfathering to specify that a change in the insurance carrier underwriting benefits will not necessarily cause a plan to lose its grandfathered status. That said, one is left with the distinct impression that the regulators would like to push employers away from grandfathering and into the broader regulation provided for non-grandfathered plans, and it is probably safe to assume that whatever revisions are made in the final regulations will not make it markedly easier for employers to maintain grandfathered status.

with the Act, and it is permissible for a self-funded plan to replace its third-party administrator *as long as* the provider network or other terms of the coverage do not change. In addition, the replacement or addition of an insurance policy or insurance issuer, or change in a plan's funding mechanism from fully-insured to self-funded (or vice versa), will not cause the loss of grandfathered status if such change becomes effective on or after November 15, 2010.

Even where an employer otherwise complies with the foregoing requirements, two anti-abuse rules also apply under the Act, and violations of either of them will cause a loss of grandfathered status. The Act generally precludes the use of corporate transactions as a means of trafficking in grandfathered plans and indicates that if the principal purpose of such a transaction is to extend coverage under a nominally-grandfathered plan to individuals who were not previously eligible for coverage, the plan's grandfathered status is lost. In addition, the Act prohibits the transfer of individuals covered by a grandfathered plan into another plan where (1) when comparing the terms of the transferee and transferor plan as of March 23, 2010, and treating the transferee plan as an amendment of the transferor plan, the transferor plan would lose grandfathered status, and (2) there was no bona fide employment-based reason to transfer the employees. Changing the terms or cost of coverage does not qualify as a bona fide employment-based reason to transfer employees.

All grandfathered plans must disclose their grandfathered status to their participants in any materials that describe the benefits provided under the plan or coverage (i.e., evidence of coverage booklets, summary plan descriptions, summaries of material modification, open enrollment materials, etc.). The plan or insurance carrier must describe the benefits that will be treated as grandfathered, provide contact information for questions and complaints (model language has been provided by the DOL), maintain records documenting the terms of the plan or coverage as in effect on March 23, 2010 and any other documents needed to verify, explain, or clarify the plan's status, and make such records available for examination, for as long as the plan or insurance carrier takes the position that the plan is grandfathered.

What must non-grandfathered plans do?
In addition to the requirements discussed above that apply to all group health plans, non-grandfathered plans are subject to a number of additional requirements under the Act.

Preventive care services must be covered at 100%. As of the Effective Date, non-grandfathered group health plans must provide coverage for the following preventive services without imposing any copayments, co-insurance, deductibles, or other cost-sharing requirements:

- evidence-based items or services recommended by the United States Preventive Services Task Force;
- immunizations for routine use recommended by the Center for Disease Control; and
- evidence-informed preventive care and screenings.

Cost-sharing is permitted for other treatments, even if they result from a preventive service that must be provided under the regulations. Cost-sharing is permitted for treatment only when preventive services are billed separately or are not the primary purpose of a visit. Plans are not required to cover preventive services delivered by out-of-network providers and can also impose cost-sharing requirements on such services. Plans may continue to provide incentives for wellness by providing premium discounts or additional benefits to reward healthy behaviors, by rewarding high-quality providers, and by incorporating evidence-based treatments into benefit plans. However, penalties (such as cost-sharing surcharges) may not be allowed. Many non-grandfathered plans and SPDs may need to be amended to address these requirements.

Nondiscrimination rules. Existing law limits favorable tax treatment for group health benefits that are provided on a discriminatory basis (i.e., better benefits are provided to highly-paid employees than are available to lower-paid employees) under self-funded plans; violations of this limitation results in adverse tax treatment for the highly-paid employees who receive discriminatory benefits. The Act expands this existing limitation to apply a similar rule to non-grandfathered fully-insured plans beginning on the Effective Date. Under this rule, fully-insured health benefits provided solely to highly-paid employees (e.g., fully-insured executive medical plans) will be prohibited. Fully-insured health plans also must benefit at least 70% of all employees in order to avoid sanctions. For purposes of the new requirement, a "highly-compensated employee" is identified in the same manner as under Code Section 105(h), and the covered group includes the top five highest-paid officers and shareholders (of at least 10% of the company) and the highest-paid 25% of employees (there is no minimum dollar threshold for this determination).

For employers familiar with the existing nondiscrimination rules applicable to self-funded plans under Code Section 105(h), it is important to note that sanctions for violations of the new nondiscrimination requirements for fully-insured benefits are more significant. The new requirements provide for an excise tax penalty payable by the employer of $100 per day for each non-highly-compensated employee who does not benefit from the discriminatory arrangement. In other words, if an employer sponsors a discriminatory health plan covering 1,000 employees, 250 of whom are highly-compensated employees, the $100 a day penalty will apply to 750 individuals, for a total penalty of $75,000 per day (up to a maximum of $500,000). Thus, simply grossing up the highly-paid employees to cover the cost of providing discriminatory coverage will probably not be a viable alternative for avoiding the impact of the new requirement. In addition, the nondiscrimination requirements can present some tricky issues for employee agreements having only limited relation to an employer's group health plan. It is relatively common for severance arrangements (including those incorporated into employment and similar agreements) to provide for "subsidized" COBRA coverage as part of a severance package, particularly for more highly-paid employees; this coverage might be offered at no cost or the employer might instead agree not to pass through the full cost of COBRA coverage. Regardless of the approach, if this benefit is not made available on a nondiscriminatory basis — and for purposes of the Act, this essentially means "made available to all employees in the plan" — the nondiscrimination requirements are likely to be violated, triggering what may be a disproportionately large penalty on the employer. At least until further notice, employers may continue to provide subsidized COBRA benefits on a discriminatory basis via after-tax cash payments or reimbursements, although even this may be an imperfect solution: in some cases, such after-tax payments or reimbursements may be affected by Code Section 409A's requirements for deferred compensation arrangements. Employers with non-grandfathered fully-insured health arrangements should carefully review executive employment and severance agreements to identify any potentially discriminatory provisions, and amend them if necessary.[8]

Claims and appeals process. The Act expands the existing ERISA requirements for claims and appeals procedures for both insured and self-funded plans that are not grandfathered to include the following new elements:

- Claimants must be allowed to present evidence and testimony.
- Coverage must be continued for claimants pending the outcome of the appeals process.
- Claimants are entitled to an external review process.

[8] As with any arrangements to which Code Section 409A may apply, great care must be taken in making any such changes: Code Section 409A may be violated when changing time or form of payments, and counsel should be consulted regarding any such amendments before they are adopted.

- The definition of "adverse benefit determination" is expanded to include a rescission (i.e., a retroactive denial, reduction, or termination of coverage).
- Claimants must be notified of a determination relating to urgent care as soon as possible, but in any event within 24 hours, after receipt of the claim, whether or not the determination is adverse; the previous standard was 72 hours.
- To provide a "full and fair review" of a claim, if the reviewer either considers or creates new or additional evidence or determines that it may deny the appeal based on a new or additional rationale, then it must automatically provide a copy of such new evidence to the claimant free of charge. The reviewer also must notify the claimant of the rationale sufficiently in advance of the adverse determination so that the claimant has time to respond before the adverse determination is finalized.
- The party reviewing claims and appeals must be must be independent and impartial from the plan or insurer so as to avoid potential conflicts of interest. A decision-maker cannot be hired, promoted, or paid a bonus based on the likelihood that the benefit denial will be upheld.
- Additional information must be provided in notices of denial for both claims and appeals (model notices will be supplied by the DOL).
- If a plan covers at least 100 enrollees a significant portion of whom speak the same non-English language,[9] then all communications about the appeal processes must include a notice in that language explaining that communications relating to claims and appeals are available in that language. Once an enrollee makes a request for foreign language communications, all subsequent notices must be in that language. If a plan covers fewer than 100 enrollees, the same requirement applies if 25% or more of the plan's enrollees speak the same non-English language. If the plan maintains a telephone hotline, communications must also be available in the foreign language. This language requirement appears to apply to all plan communications, not just those regarding appeals and denials.

Beyond the foregoing requirements, fully-insured plans must comply with each state's external review requirements, while self-insured plans must comply with the external review standards set by the Secretary of Health and Human Services in regulations to be issued. These new procedures are effective for plan years beginning on or after September 23, 2010, but there is a good-faith compliance grace period until July 1, 2011.[10] This transitional relief temporarily allows fully-insured plans to use existing state external claims and appeals processes.

Documentation for non-grandfathered plans (including plan documents, SPDs, and related insurance certificates and policies) should be amended to comply with these new requirements at least 60 days prior to July 1, 2011.

Choice of Health Care Professionals. The Act expands the ability of enrollees to select their primary care physicians in many situations. Enrollees may designate any available participating primary care provider or pediatrician, and plans may no longer require preauthorization or referrals for OB/GYN services. This rule applies to both insured and self-funded plans that are not grandfathered, and is effective for plan years beginning on or after September 23, 2010. Depending on the particulars of their existing design, some plans and related insurance certificates or policies may require amendment to implement this requirement.

[9] For this purpose, a "significant portion" of the plan's enrollees is equal to 500 enrollees or 10 percent of the plan's total enrollment, whichever is less.
[10] The grace period applies to the following portions of the new claims and appeals rules: (1) 24-hour time frame for making urgent care claims decisions (shortened from 72 hours), (2) provisions of notices in a culturally and linguistically appropriate manner; (3) inclusion of broader content and specificity in notices, and (4) determination of when a claimant will be deemed to have exhausted the plan's or issuer's internal claims and appeals process due to the failure to strictly adhere to all the requirements of the interim final regulations.

Coverage for Emergency Services. Plans that cover emergency services may not impose preauthorization requirements or increased cost-sharing requirements (i.e., coverage must be the same) for emergency services, whether provided in or out of network. Detailed cost-sharing requirements apply for out-of-network emergency services. This rule applies to both fully-insured and self-funded plans that are not grandfathered. Depending on the particulars of their existing design, some plans and related insurance certificates or policies may require amendment to implement this requirement.

New Notices. The following additional notices are required to be provided under the Act for non-grandfathered plans:

- Claims and Appeals Notices (see discussion above).
- Notice of Right to Designate a Primary Care Provider and to Use an Obstetrician or Gynecologist.

EXCEPTIONS TO THE ACT

While the Act's new requirements apply broadly to group health plans, there are certain exceptions to its mandates. These include the following types of benefits and plans.

Dental and vision benefits. Dental or vision benefits that are "excepted benefits" under HIPAA are excluded from coverage under the Act. Dental and vision generally are excepted benefits under HIPAA if they (i) are offered under a separate policy or certificate of insurance, or (ii) are not an integral part of the plan, i.e., are elected separately for additional (even nominal) premiums. The excepted benefit rules can be complex in operation and are highly dependent on the facts and circumstances, so employers should carefully consider dental and vision benefits that may be provided on a "unbundled" basis as part of their group health plans before concluding that the Act does not apply to those benefits.[11]

Government plans. The Act applies to self-insured state and local governmental employer group health plans, but the sponsoring entities may opt out of some of the Act's requirements. Previously, such plans could opt-out of certain provisions of the Public Health Service Act, but the Act now prevents governmental employers from opting out of limits on pre-existing condition exclusions, requirements for special enrollment periods, and prohibition on discrimination based on health status, regardless of their plans' grandfathered status. The elimination of these opt-out provisions may be enforced for plan years beginning on or after April 1, 2011.

RECOMMENDATIONS

The Act represents a significant change in the regulatory regime that applies to group health plans, and virtually every plan will require at least some modifications to comply with current and future requirements. For employers who do not elect to grandfather their plans for 2011, the required updates are likely to be significant, although actual changes in plan administration may be relatively small depending on the existing plan design. For employers choosing to grandfather their group health plans, the modifications may not be extensive at first, but the ongoing compliance efforts necessary to preserve grandfathered status in future years may ultimately prove unworkable or uneconomical. Regardless, careful consideration of existing plan documents, SPDs, and insurance materials should be undertaken to identify and address any compliance gaps with respect to requirements taking effect on January 1, 2011. In making these changes, employers should bear in mind the Act's new requirement to provide an updated SPD or summary of material modifications to

[11] Of some interest here, employers should bear in mind that it is possible for dental or vision benefits that are provided through a single group health plan to nonetheless be excepted benefits under HIPAA and therefore escape the Act's mandates.

participants at least sixty days prior to the effectiveness of any material changes they make to their group health plans.

In addition, employers with fully-insured health arrangements that do not have grandfathered status under the Act, or which may lose grandfathered status at some time in the future, should review all employment agreements and other arrangements for highly-compensated individuals to make sure that the new nondiscrimination requirements are not violated, and amend them if required.

As we noted at the outset, this Alert does not attempt to address all of the provisions of the Act that became effective in 2010 or beyond, and employers and others working with group health plans should be sure to carefully analyze the Act to identify any other requirements that may require action.

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